WIC Breast Pump Request for Reimbursement

Agency/Clinic Name:

Phone Number: _____ FEIN Number: _____

Expenditure for the month of:

Directions: Complete the following information to receive reimbursement for the purchase of breast pumps and/or collection kits. *Include tax, shipping and handling charges in the expenditure total. Attach a copy of all receipts.*

Expenses: Indicate the total breast pump expenses incurred this month:

Pumps and Collection Kits	$
Shipping and Handling	$
Taxes (if any)	$
Total Reimbursement Requested	$

Quantity: Indicate the quantity and unit price of breast pumps and collection kits purchased this month:

ITEM	QUANTITY	UNIT PRICE
Manual Breast Pumps		
Collection Kits - single		
Collection Kits - double		
Hospital Grade Electric Breast Pumps		

Quantity purchased estimated to last 1 2 3 4 5 6 months (circle one)

If LA and/or sub-agencies went together to order breast pumps, please list all involved with this transaction and quantities distributed to each agency. *(Only 1 LA may submit reimbursement request)*

Signature _____ Date